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Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory

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Abstract

Domestic violence (DV) against women is a widespread violation of human rights. Adoption of effective interventions to address DV by health systems may fail if there is no readiness among organizations, institutions, providers and communities. There is, however, a research gap in our understanding of health systems' readiness to respond to DV. This article describes the use of a health system's readiness assessment to identify system obstacles to enable successful implementation of a primary health-care (PHC) intervention to address DV in the occupied Palestinian Territory (oPT). This article describes a case study where qualitative methods were used, namely 23 interviews with PHC providers and key informants, one stakeholder meeting with 19 stakeholders, two health facility observations and a document review of legal and policy materials on DV in oPT. We present data on seven dimensions of health systems. Our findings highlight the partial readiness of health systems and services to adopt a new DV intervention. Gaps were identified in: governance (no DV legislation), financial resources (no public funding and limited staff and infrastructure) and information systems (no uniform system), co-ordination (disjointed referral network) and to some extent around the values system (tension between patriarchal views on DV and more gender equal norms). Additional service-level barriers included unclear leadership structure at district level, uncertain roles for front-line staff, limited staff protection and the lack of a private space for identification and counselling. Findings also pointed to concrete actions in each system dimension that were important for effective delivery. This is the first study to use an adapted framework to assess health system readiness (HSR) for implementing an intervention to address DV in low- and middle-income countries. More research is needed on HSR to inform effective implementation and scale up of health-care-based DV interventions.

Keywords: Domestic violence, violence against women, health systems research, qualitative research

Introduction

Violence against women (VAW) is a widespread violation of human rights that can damage physical and mental health. Domestic

violence (DV) is one of the most prevalent forms of VAW (World Health Organization, London School of Hygiene and Tropical Medicine, and South African Medical Research Council, 2013).

Key Messages

- Despite being considered critical for successful implementation of complex interventions, health system readiness has received limited attention in research on domestic violence, where the focus has been individual provider and/or health facility readiness.
- Using our proposed framework for health systems readiness assessment for domestic violence, our findings reveal interlinked gaps in the Palestinian study facilities. These cut across system dimensions and levels (macro and meso), where weaknesses in one dimension have a knock-on effect on other system dimensions.
- The Health Systems Readiness Assessment highlights the critical influence of ‘software’ issues of the health systems (e.g. values, leadership and support) on collective readiness.
- Integrating health systems readiness assessment as a precursor to the implementation phase of a pilot intervention can anticipate preparedness gaps and inform intervention adaptation that will enhance uptake and effectiveness.

For the purpose of this study, we drew on the Palestinian Violence Survey definition of DV including physical, sexual or psychological abuse perpetrated by spouses or other household members (Palestinian Central Bureau of Statistics, 2011). Integrating responses to DV within the health sector has become a global priority (67th World Health Assembly, 2014; 69th World Health Assembly, 2016). Responding to DV requires a comprehensive, multi-faceted public health response that goes beyond purely clinical considerations and demands attention to both systems’ ‘hardware’ (e.g. clinical protocols, resources and infrastructure) and ‘software’ (provider, client and community attitudes and willingness to address) (Sheikh et al., 2014). Recently, there has been increased discussion of the need to assess the capacity of health systems to integrate promising interventions to address VAW (García-Moreno et al., 2015). Trials and pilot projects addressing DV in health services report uncertain effectiveness, and there has been little consideration of the broader, systemic and structural factors that affect the outcomes. Even when interventions are found to be effective in one setting, they may not improve patients’ outcomes when implemented across multiple settings (Burnes, 2004) if the necessary health system elements required to support their implementation are not taken into account. A deeper understanding of the readiness of a health system to address DV will help us understand why interventions may work in some health-care settings and not others.

Readiness refers to the extent to which an organization is both willing and able to implement a particular innovation (Weiner et al., 2008; Weiner, 2009). It is considered a necessary precursor to successful organizational change and, thus, is often embedded within larger programme planning and implementation frameworks (Greenhalgh et al., 2004; Damschroder et al., 2009). Health system readiness (HSR) focuses on the preparedness of health-care systems and institutions to accept the change brought by the integration of the new service. In research on VAW, despite being considered critical, such assessment is often limited to individual provider-level (Leung et al., 2017; Po-Yan Leung et al., 2018) or facility-level factors that need to be strengthened (World Health Organization, 2017) with less attention to the health system dimension, which is crucial for the successful implementation of complex interventions (Weiner, 2009; Dutton et al., 2015; Leung et al., 2017).

As provider- and facility-level readiness, HSR is a combination of various elements requiring an organizational level of analysis (Weiner, 2009). Few disease- or service-specific frameworks for systems’ readiness are available for adaptation (Mikton et al., 2011), and even fewer specific to VAW and DV (Colombini et al., 2012; World Health Organization, 2017). Although existing frameworks

propose multiple and interlinked dimensions for assessing readiness (e.g. key actors’ attitudes and knowledge, availability of scientific data, willingness and motivation and resources), only few studies have attempted to analyse them jointly (World Health Organization, 2013).

This article describes the use of a HSR assessment tool to identify obstacles and highlight changes required to enable successful adoption of an intervention to address DV in primary health-care (PHC) settings in the occupied Palestinian Territory (oPT). Violence from a spouse is widespread in oPT. A 2011 survey on VAW showed that ~37% of married women had been exposed to at least one form of violence by their husbands including physical, sexual, psychological, social and financial violence (Palestinian Central Bureau of Statistics, 2011). A higher prevalence of up to 73% has been found in clinic-based studies in Arab countries (Hawcroft et al., 2019). The oPT has a National Referral System (NRS) for VAW aiming to provide a comprehensive framework for co-ordinating referral to services for DV survivors across various public sectors [e.g. Ministry of Health (MoH) and Police and Ministry of Social Development] and non-governmental organizations (NGOs) (Arab World for Research and Development, 2016). The health sector in oPT is centralized with the MoH as one of the main providers of care, though PHC is more fragmented (Giacaman et al., 2009; Khatib et al., 2016; AlKhaldi et al., 2018). The MoH developed a health response to DV in some PHC clinics in the West Bank, including identification of cases and referral to external support services. However, this health-care response is limited in terms of staff training and co-ordination of referrals (Airifai, 2017).

This study contributes to DV evidence base by generating a framework to explore health system functions and provide information that could facilitate successful adoption of DV interventions in oPT. We describe the framework and the methods used for conducting the HSR assessment, present the main findings and reflect on the framework’s usefulness in capturing the needed information.

Methods

Study design

We used a case study design using qualitative methods (interviews and a stakeholder meeting), structured health facility observations and a document review (Yin, 2009). The aim of this case study is to assess the HSR to adopt a bespoke PHC intervention to address DV in oPT. We have used a specific conceptual framework for analysing the data of the case study.

Table 1 Key baseline characteristics of the study clinics

	Clinic 1	Clinic 2
Location and number of women who visited the clinic in past month	<ul style="list-style-type: none"> Located in Area C (under the Israeli authority) 792 women Serves 16 000 people 	<ul style="list-style-type: none"> Located in Area B (Palestine civil control and joint Palestinian-Israeli security control) 594 women Serves 11 000 people
Number of DV cases recorded	<ul style="list-style-type: none"> 4 DV cases (physical and economic abuse) 	<ul style="list-style-type: none"> 0 DV cases
Staff composition	<ul style="list-style-type: none"> Clinical staff: 11 (5 doctors—1 coming to antenatal clinic twice a week; 6 nurses) 	<ul style="list-style-type: none"> Clinical staff: 7 (4 female nurses; 3 doctors)
Leading GBV staff	<ul style="list-style-type: none"> No specific DV co-ordinator on site. Primarily, nurses in vaccination and pregnancy clinics should be able to deal with DV cases 	<ul style="list-style-type: none"> 1 female nurse at gynaecology clinic
DV services offered on site	<ul style="list-style-type: none"> Basic medical treatment Basic counselling Referral to MoH central office for mental or psychological services 	<ul style="list-style-type: none"> Basic medical treatment Referral to mental or psychological services (to the MoH central office)
DV training	<ul style="list-style-type: none"> Only 1 training for nurses trained by MoH GBV focal point 	<ul style="list-style-type: none"> Only nurses were trained on referral system (1 day training at the MoH and 2 days training with local NGO)
DV identification	<ul style="list-style-type: none"> DV screening conducted at the gynecology clinic and cases also identified at paediatric clinics (vaccination) and general medicine 	<ul style="list-style-type: none"> Done by nurses in antenatal care (first visit); at family planning clinics (once a year)
DV documentation and registration	<ul style="list-style-type: none"> DV data collection form available DV registry available at clinic 	<ul style="list-style-type: none"> DV registry available at clinic, registration done by nurses
Referral	<ul style="list-style-type: none"> GBV focal point at central office of MoH in Hebron 	<ul style="list-style-type: none"> Only to MoH central Office in Bethlehem (for mental health services) Referral to the MoH occurs through the MoH GBV focal point
DV protocols	<ul style="list-style-type: none"> DV written protocols from the MoH National Referral System Manual (and forms) Co-operation agreement with the mental health clinic in the central MoH clinic 	<ul style="list-style-type: none"> DV written protocol and forms of the referral system Co-operation agreement with the mental health clinic in the central MoH clinic
Privacy and confidentiality	<ul style="list-style-type: none"> No private room for DV screening and counselling 	<ul style="list-style-type: none"> Limited as no private room for DV screening
DV information material	<ul style="list-style-type: none"> DV brochures are available in the corridors 	<ul style="list-style-type: none"> No DV posters on walls and no leaflets available in waiting rooms Leaflet only given to women during DV screening if the woman asks
Infrastructure & supplies	<ul style="list-style-type: none"> No private room for consultations No hepatitis B vaccine, forensic examination items or sanitary towels 	<ul style="list-style-type: none"> No private room for consultations No HIV tests, hepatitis B vaccine, forensic examination items or sanitary towels

Study settings

The HSR assessment study was implemented in two PHC clinics in the West Bank of oPT. [Table 1](#) presents key characteristics of the clinics based on the health facility observations conducted in November 2017 prior to implementation of the intervention.

Data collection and sampling

The following data were collected during the formative evaluation/research phase of the Healthcare Responding to Violence and Abuse study, between June 2017 and March 2018:

- Document review of the national regulatory framework around DV: to analyse available health policy documents and reports (16), guidelines (2) and published articles (8) related to VAW;
- Twenty-three semi-structured interviews with: PHC providers (10) and health managers (2) at the two study clinics (who consented to be interviewed), senior policy-makers at PHC and district and national levels who had expertise on DV programming

and policy-making (6) and experts from local NGOs offering DV services (5);

- One stakeholder meeting with 19 stakeholders from various ministries, NGOs and international agencies working on VAW. They were selected on the basis of their expertise and experience on DV service provision; and
- Two structured non-participant health facility observations of the clinics' services and activities to assess material resources (human, financial and technical).

Qualitative interviews explored values and beliefs around DV; knowledge of DV protocols, procedures and specialized DV services; and experiences with delivering DV cases. The interviews were conducted in Arabic by trained researchers. They took place at a private location in the study facilities (for providers and managers), or in a location proposed by the respondents (for policy-makers and DV experts). Upon consent, the interviews were recorded and subsequently transcribed and translated into English.

Table 2 Key dimensions of health system readiness to address DV

HS dimensions	Values	Leadership and governance	Financing and other resources	Co-ordination and community engagement	Health workforce	Infrastructure and supplies	Information
Indicators at macro level (examples)	<ul style="list-style-type: none"> Supportive values and attitudes among health policy-makers' (e.g. acknowledgement of DV as a public health problem) 	<ul style="list-style-type: none"> Laws on DV/VAW National protocol on DV/VAW response Health policy-makers' willingness and agency to support roll out of DV services 	<ul style="list-style-type: none"> Dedicated budget line for DV/VAW response 	<ul style="list-style-type: none"> National and sub-national multi-sectoral partnerships (e.g. memorandum of understanding) Mechanisms for DV/VAW multi-sectoral co-ordination (e.g. DV Co-ordinating Committees) 	<ul style="list-style-type: none"> National co-ordinator on DV/VAW at MoH National training on DV/VAW 	<ul style="list-style-type: none"> Guidance (e.g. policy directive or guideline) that defines what infrastructure should be expected at the different levels of health-care services to respond to DV, and what supplies should be available for DV response 	<ul style="list-style-type: none"> Existence of systems and procedures for collecting and compiling DV/VAW data from health-care services and documenting follow-up care (e.g. referrals offered and taken up)
Indicators at facility level (meso) (examples)	<ul style="list-style-type: none"> Supportive values and attitudes among health managers' and health staff 	<ul style="list-style-type: none"> Facility standard-operational procedures for dealing with cases of DV Health managers' and staff willingness and agency to champion and implement DV services 	<ul style="list-style-type: none"> Dedicated human, material and technical resources 	<ul style="list-style-type: none"> Local referral network between health facility and support services (health and non-health) Sensitization activities on DV at community level Working with local NGOs/local leaders to raise awareness on DV 	<ul style="list-style-type: none"> Dedicated and trained staff for dealing with DV Training on DV for health staff (e.g. regular and annual) System in place to support trained staff 	<ul style="list-style-type: none"> Availability of private examination rooms/areas for providing care Availability of drugs and supplies for DV cases 	<ul style="list-style-type: none"> DV data collection forms (or separate register for DV cases)

HSR framework

The case study aims to explore the health systems readiness dimensions of our conceptual model presented in Table 2. The proposed framework is based on a World Health Organization (WHO) tool on policy readiness for VAW (World Health Organization, 2017). We expanded the WHO policy tool to include a broader system focus and expand some of its dimensions. The adapted framework consists of seven key health systems dimensions: six based on mainstream health systems frameworks and one cross-cutting dimension of 'values' (World Health Organization, 2007; 2017; de Savigny and Adam, 2009), which was added as a stand-alone element. We focused on both macro- (national and subnational levels) and the meso/facility-level factors and their interconnections to assess the material capacity of the designated health facilities and understand operational readiness at meso/facility level.

Data analysis

Data from the four sources (described earlier) were initially analysed separately. Qualitative data were analysed thematically (Miles and Huberman, 1994), and NVIVO 11 was used to organize and code the data. Four interviews were double-coded by two researchers (MC and LJB) to develop and achieve consensus on the initial coding framework. Local investigators participated in the data analysis (through in-person and remote sessions) to help identify key codes and emerging themes and interpret and contextualize the results. Following the deductive coding process (guided by the HSR framework), a deeper analytical and inductive process of the analysis—jointly with UK and local partners—began to identify overarching themes. Each main theme was subsequently analysed using matrices in Word to identify and explore sub-themes and connections among these. Information collected from the health facility observations was analysed descriptively to assess the HS dimensions on infrastructure, supplies and availability of resources. The information collected from the document review of several national policy and legal documents and reports on DV informed the dimension of governance and leadership. The results from each of the four data sources were subsequently analysed jointly through a matrix—using HS dimensions based on the conceptual framework—allowing for both cross-case comparison across data sources as well as sorting data by system dimensions and levels (e.g. macro and meso). Key questions explored during the analysis are listed in Table 3.

Results

We report findings for seven dimensions of health systems that impact on readiness to integrate DV interventions. Findings from each dimension are described below.

Values: recognition of DV as a public health issue and key role for the health sector

Interviews with officials showed that they were aware of VAW and its high prevalence. Most recognized DV as a major public health issue rooted in gender inequality and power imbalances. Several officials acknowledged the culture of silence surrounding DV within the community, where DV is considered a private matter and women are blamed for the abuse.

We are dealing with a community that says 'she deserves it' without understanding the circumstances. The victim is the one blamed and there is social culture understanding that we [women] hold onto what is unacceptable and we get involved in

something we have nothing to do with, we are ruining our families... (Off 03).

Some stakeholders raised concerns about ideological differences in VAW responses across sectors, where some policy-makers viewed discussion of DV as a taboo.

[...] this [DV] is a difficult issue. It involves a certain ideology. The challenges involve the resistance of some people towards a certain ideology'. [...] Gender based violence, in English, is very easy to talk about, in Arabic abuse is not connected to female abuse [...] Yes, because people still don't think it's appropriate [to discuss it] (Off 01).

There was some consensus among stakeholders regarding the critical role of the health sector in responding to DV, especially in the Palestinian context where women have limited freedom of movement.

Health sector is one of the most important sectors that we consider because it is the 'filling'. We encourage [women] to come here and talk about the violence, so the health sector should be the most sensitive to cases of violence (Official, Stakeholder Meeting).

The awareness of DV as prevalent and positive endorsement of the health sector role at the national health policy level was not consistently apparent at the facility level. PHC providers expressed mixed views about their role. For some, including district health managers, DV was a private family issue and not part of the common role of a provider.

Look, this is a matter of her personal relationship with her husband... I don't have any involvement in that. I can't... I'm not a tool to solve a problem that has happened between her and her husband. I'm a healer for the patient. [...], because it's [DV] a personal topic between her and her husband (HP01).

Many providers saw DV as a mental health issue, highlighting their limited capacity to deal with its emotional aspect. Several perceived access to mental health specialists as an alternative to the engagement of PHC providers and stressed the importance of referral to mental health teams.

I don't feel that it [DV] is [a topic for nurses]. [...] I mean, a social worker, a psychologist [should be responsible]. Of course, we study these subjects throughout our studies, but... it is for certain people, it's not for everybody (HP04).

[VAW] it's not just about the physical health, it's about the psychological health of the patient as well. There are social stories like her relationship with her husband, her family... so I feel like it's difficult for a doctor, a general practitioner or a family doctor, to handle on their own. [...] Without a team from the mental health division, they can't do anything. They need a social worker and counsellor to visit the home and consider the conditions of the family and all of that, and that's not the doctor's job (HP12).

Some managers saw DV as a Western concept and feared that addressing it during health staff training may erode traditional norms relating to the woman's role in protecting marriage, family honour and privacy.

When they asked me to come train in the doctors' administration in [name of city] a lot of them didn't accept what I was giving out. [...] One of the supervisors told me: 'You're going to train us that a woman should always have her bag prepared so that anytime her husband says a word to her, she can just grab her

Table 3 Readiness questions explored during the data analysis and sources of data

HS framework dimensions for readiness	Readiness questions	Sources of data used for each dimension
Values	Are values, norms and attitudes of key actors supportive of DV responses?	IDIs with providers, health policy-makers, health managers and key DV experts
Leadership and governance	Is there a regulatory/policy framework and support system to address DV in PHC?	IDIs with health policy-makers, health managers and key DV experts; document policy analysis
Financing and other resources	Are there dedicated resources (human, material) for integrating DV services in PHC?	Facility observations; IDIs with health managers, health policy-makers and key DV experts
Co-ordination and community engagement	Is there collaboration across services and organizations to guarantee appropriate referral? To what extent is the community engaged in the DV response?	Document review; facility observations; IDIs with providers, health policy-makers, health managers and key DV experts
Health workforce	Are training and support structures in place? Are health providers motivated, prepared and comfortable with addressing DV within their work?	Document review; facility observations; IDIs with providers, health policy-makers, health managers and key DV experts
Infrastructure and supplies	Are the existing infrastructure and supplies at PHC clinic adequate for integrating the new DV intervention?	Facility observations; IDIs with health managers and providers
Information	Is there a process for identifying and recording identification and care of DV survivors?	Document review; facility observations; IDIs with health managers and providers

IDIs, in-depth interviews.

bag and leave. You're bringing Western [culture] here and leaving' (HP03).

Governance: limited health guidance, perceived lack of management support and unclear roles

The review of policy documents and published reports, alongside the qualitative interviews with officials, revealed policy gaps and a lack of national and subnational support and guidance on DV—and more broadly on VAW and women's rights.

[...] from the laws issued by the President, more than 100 laws issued, 1% of them touch on justice for women's rights...the case of women is not a priority on the Palestinian official agenda...[...]. We still have a long road ahead (Off 03).

A national policy machinery on DV started to develop in the past decade showing increased high-level political will to address the issue. Significant policy accomplishments to address VAW included: the National Committee to combat VAW and its related National Strategy (2011–19) and the recent draft of 'The Law to Protect Family from Violence' (Italian Development Cooperation and Ministry of Foreign Affairs and International Cooperation, 2015). Nonetheless, the implementation of a national accountability structure on DV was affected by the limited government endorsement for a DV response, which also failed to legitimize the health sector role on DV.

The implementation [of DV response] is more difficult because the system has not been put in place straight away [at the national level]. Yes, you need a system to help you. If it is not there, how are you going to work without a system? [...] the government is an important part of this so [it] needs to be involved in it. It would help if the government endorsed, signed and adopted the system (Off 01).

The respondents' narratives seem to point to a leadership vacuum on VAW at national level resulting from the political occupation, the absence of a formal governmental authority in parts of the

oPT (Human Rights Council, 2017) and the lack of government endorsement of the VAW policy. This leadership vacuum, combined with no laws to protect health-care providers and citizens and the absence of police protection in the occupied areas, also affected all VAW interventions on multiple levels. For instance, the quote from an NGO senior staff hinted at the limited confidence among health staff to help abused women because of the constraints imposed by the political occupation.

[...] there was the problem of transitioning between Palestinian areas and Israeli areas. We would find ourselves not knowing where to go with the ladies (Off 03).

Recent MoH documents (e.g. National Strategy on Reproductive Health, circular on fee exemption for medical reports for any VAW cases, including DV ones) (Airifai, 2017) and some officials' responses pointed to an attitude and interest shift in the Health Ministry, suggesting that the new MoH administration was taking a more active role in institutionalizing the response to VAW within its policies and programmes.

[...] There was a sluggishness and neglect, and lack of response from the health sector that represents the Ministry of Health... It was only until the beginning of 2017 that we felt an increase in their attention to it. They might have done something about new procedures and new strategies, that's what I understood. Their concern for it increased (Off 11).

Furthermore, the shift in MoH political endorsement of VAW was reflected in the creation of a designated gender-based violence (GBV) focal point staff in each directorate. However, some officials pointed to the lack of support from senior health leadership, which combined with negative values on DV (and VAW) among some district health managers and weakened the agency of GBV focal points that was responsible for the follow-up and external referral of severe cases.

The third and most important, you have to build the capacity of the people in the health sector, from the top to the bottom so that the employee that works hard and wants to report his work with

a woman after 4 or 5 hours of convincing her, goes to report to [name of his/her superior], all so that his director might tell him 'enough. Let her go, I don't care if she dies. It's not my problem to get involved and into a problem with her husband. Don't get me involved in these tribal issues.' Here I have problem (Off 07).

The limited higher-level support and guidance on VAW was also reflected in the lack of clarity regarding the role of GBV focal points at policy level.

It's not clear to me right now what their [GBV focal points] roles are exactly. Are they political, and have a hand in administration? Or are they front line service providers? It isn't exactly clear the model (Official, Stakeholder Meeting).

Both officials and some PHC clinicians also referred to the lack of clear DV guidelines and protocols response and the absence of accountability measures as common challenges.

I should at least be following a certain protocol, have certain questions to start talking with the patient, for example. I don't think I'm the only one who wouldn't innovate questions on my own. I should be subject to specific training and following guidelines. I'm sure there are global guidelines for this kind of thing (HP11).

Limited availability of resources and of private space for DV identification

Participants reported limited budget allocation for VAW within MoH. International donors, namely the United Nations Population Fund, provided most of the funding to support health and VAW-related projects. PHC received the support from the mental health section of the Department of Health (in terms of specialist mental health staff), though such services were not provided on site at PHC clinics.

Interviews with providers showed that study clinics were characterized by heavy workload, limited staff and regular staff rotation in Bethlehem area, making the integration of responses to DV challenging for the providers.

[...] Here, we are 3 nurses and we fulfil our duties, but it is all at our expense. If there are more services [for us to offer] it would be too much (HP04).

Privacy, which was often lacking at the study clinics, was also identified by many as a concern. Initial discussions about DV were often conducted in open spaces (e.g. examination room) either with other women and PHC providers present or in the corridor of the waiting room area.

With regard to space, there are 4 clinical rooms and a room for vaccinations, and each is full. Where am I supposed to receive this woman? (Official, Stakeholder Meeting).

Lack of intersectoral co-ordination on DV and limited involvement of the health sector

Our results show limited application of the NRS processes at health service level, possibly justified by the recent MoH engagement and the low awareness of such system in the health sector (Arab World for Research and Development, 2016; Airifai, 2017).

Several officials doubted whether the referral system was working effectively across all sectors and administrative areas, especially when only a few ministries were involved, and support services were not always available in all areas.

Some stakeholders suggested a deeper lack of communication and co-ordination across organizations and institutions working and offering training on DV, often led to duplication and wasted resources.

I feel like there is duplication of services...there isn't communication between the organizations that do anything. They all serve for violence against women and the Palestinian people but its resources and money being used up. [...] When something happens, there needs to be links between the organizations (Official, Stakeholder Meeting).

Even within the health-care sector, the lack of standardized guidance and limited clarity around institutional roles also affected co-ordination between MoH and external organizations.

Honestly, [...] until this moment, as the referral system is concerned, for us to know the guidelines or our roles rather...what exactly is my role, as the Ministry of Health? What is Family Protection's role exactly? What is the job description for the other organizations? I don't know where the roles start and where they end...[...] Do I get involved here, where do I stop? If the Ministry gets involved, might the employee be at risk? So there are criss-crossing of roles...there is a mix-up that we have not yet activated the system exactly (HP03).

At facility level, PHC providers confirmed the existence of pathways of care for internal referrals to the doctor and the MoH direct-orate social workers and GBV focal point for severe cases. For any other referrals, only the MoH GBV focal point will contact the MoH health directorate, who in turn will contact other sectors (e.g. the police, Family Protection Unit, Ministry of Social Affairs and Ministry of Women). However, findings pointed to a hierarchical internal referral system leading to limited authority of the MoH GBV focal point who has to rely on high-level senior staff to call upon the services of other sectors.

She [the PHC nurse] calls me, the [MoH GBV] focal point. I know my role as the focal point; I will have understood the problem in its entirety and directly tell my supervisor... the Director of Health [Health Directorate of MoH] with his authority calls Family Protection or other institutions (HP03).

Some health staff also reported their own limited agency and power as the existing pathways of care did not allow them to refer cases directly to support services.

I don't think I have authority to refer after I investigate her case and she's in a dangerous violence situation, I don't have authority to refer her. I fill out her form and call those in charge and report to them (HP07).

Health workforce: limited practical training, low DV knowledge and fear of family retaliation

Despite the availability of an MoH training structure at PHC clinics, where GBV focal points would train nurses and doctors on the standard procedure for DV care, our findings showed that such training was limited, targeted nurses primarily, and it was not cascaded to other clinical staff. For instance, some doctors were

unaware of how to respond to abused women and thought that only nurses were being trained.

I know that there is a program in the Ministry [of Health], in our Ministry, but unfortunately, we as cadres and staff, we don't know anything about it. Sometimes they train the nurses, but they don't even train the doctors! That is a point that I criticize the Ministry about. We, as doctors, have a role. [...] Unfortunately, we don't have any information or background on the program about women violence (HP11).

While others acknowledged the leadership role nurses could play in addressing DV cases.

Everyone is supposed to be [dealing with VAW], I'm telling you, and the nurse might start. For us, the nurse has such a big role. She has a big role. You find her during vaccinations, you find her measuring the patient's blood pressure, or taking her temperature... you find her on more than one occasion (HP11).

Some senior officials also raised concern over whether health providers understood their critical role in responding to DV and whether they were willing, motivated and sensitive and had the capacity and knowledge to deal with DV cases.

In this sector [health sector], within its structure, is there sensitivity to cases of violence against women? Is there the willingness to provide service-qualified cadres, to women in the system's structure? Health care teams that understand when to refer women, what their role is, what isn't their role, and to know the principles of dealing with these women and keep their privacy, value confidentiality and the women's freedom to talk, and all the binding things to providing this kind of service? (Off 09).

Limited knowledge on DV, alongside traditional values (DV seen as a personal issue) among staff seemed to constrain the way providers operated at facility level, leading to them avoiding involvement in DV cases. Providers who did not view DV as part of their medical role purposely chose not to ask women about DV, even when they suspected, for fear of embarrassing them or fear that women might not accept such intrusion into their privacy.

no, I won't ask them. Honestly, I won't ask them. I won't ask because I might cause her embarrassment. [...] she's come here with her son. 'What do you have to do with me?' I'm there to check out her son, not her (HP01).

Others who were motivated and suspected abuse tried to act and asked the women but became frustrated when women would not disclose assault as the cause of an injury.

I really tried. I took her to the side, by herself, she had privacy and all that and she insisted that someone had hit her with the cell phone and by accident also. So I don't know. You feel like there is violence, but no one wants to talk about it. I mean I took her aside and I was sure that this was something, I mean, it's under her eye and it was obvious that it was an intentional hit (HP09).

Stakeholders also suggested that the MoH training was not practical. Some found its content too focused on attending to physical injury and referral, with minimum attention to basic communication and counselling skills, which were seen as crucial for identifying and responding to women.

That's what we're trying to get to...communication skills, dealing skills. And that is what we are lacking, that's why I'm telling you we need particular training on that subject so that we're able to get to the women more easily (HP04).

Providers also vented their frustrations with the low referral uptake by women who experienced abuse. Some blamed their limited understanding of the procedures on DV response to the lack of referral uptake.

If you're looking at the system as a whole, there are [services] available, but like I told you, a main problem of ours is that women's responsiveness is minimal'. [...] I've said there are no benefits to them [having DV protocols] because there aren't any cases being referred. If you ask me, I haven't referred any...if you tell me about other procedures, I could give you more details, I know more about them, but I don't know much about the violence cases because I've never referred any cases. This is why you find that none of us really understand it (HP012).

Despite some political recognition at high ministerial level (MOJ), the lack of legal protection for providers was identified as a critical challenge for responding to DV, which could often lead to inaction.

The first thing is that, as an employee, there is no legal protection. That is so important. There are so many cases...incest cases, and very high risk and dangers, and it reaches the point where the doctor might get shot, or the director or someone as they're going into their car, etc. (HP03).

Providers also reported the lack of time as a major obstacle to addressing DV, especially in the mornings when they saw most patients.

Look, we are currently working on the topic of violence and are taking notice of cases and such, but, when a woman comes to us with her baby and we have a lot of traffic at work, we don't really give too much attention to the woman. We give our attention to the baby and that's it. When we have more space and chance, we sit and chat with the women and talk to her and hear more from her (HP04).

Health information: policy on DV documentation though limited implementation

Our results revealed that although oPT has a surveillance system for collating data on VAW (specifically physical and sexual violence), it was not consistently implemented. For example, study clinics were not using the NRS forms for documenting cases of DV, but separate ones developed by MoH.

Interviews with stakeholders showed that MoH had recently adopted a policy of documenting cases of survivors of violence presenting at health facilities (irrespective of whether they were referred or not). However, providers' narratives and facility observation data established that very few DV cases were recorded at the study clinics, as many women chose not to have their disclosure of abuse documented for the fear of family retaliation and societal stigma.

No, there is no record [of DV cases in the clinic], I told you the area here is a little [traditional]...if she talks [about the abuse] she might get into bigger problems (HP01).

Furthermore, in contradiction to MoH policy, providers admitted that they would only record a case if the woman agreed to be

Table 4 Summary of how the health system readiness assessment shaped the development of a bespoke DV pilot intervention in oPT (prior to implementation)

HS framework dimensions for readiness	Key findings (macro and facility levels)	Impact and suggestions for improving intervention
Values	<ul style="list-style-type: none"> Supportive attitudes towards health sector role in addressing DV among some senior officials Acknowledgement of DV as a public health problem among senior officials Some negative views among health managers Traditional attitudes among some health providers around DV (DV as family issue) Limited PHC role on DV—seen as a mental health issue (more appropriate for psychologists or social workers to deal with) 	<ul style="list-style-type: none"> Discussion on role of health providers during training sessions 3 clinic-based community awareness raising sessions on DV conducted (1 in Hebron area attended by 30 women and 2 in Bethlehem area attended by 50 women)
Leadership and governance	<ul style="list-style-type: none"> No DV law, or any protective and safety measures for health providers' safety NRS guidance on DV service co-ordination exists, although no specific national and subnational health guidelines on DV Some national accountability structure on DV exists but limited government endorsement Political occupation leading to difficult security arrangements Recent increased interest in VAW of MoH (as opposed to past leadership vacuum and no attention to it) New MoH governance structures (and policies) for addressing DV (e.g. GBV focal points at central level) but lack of MoH clear guidance on DV Limited willingness and lack of leadership among some district health managers (not wanting to get involved in DV cases) Recognition of the leadership role nurses could play in addressing DV in PHC Limited agency among GBV focal points (still need director approval for difficult DV cases) 	<ul style="list-style-type: none"> MoH willingness to support the development of specific DV clinical guidelines for health-care providers MoH recognition of limited providers' security led to the consideration of passing a policy on health-care providers' safety GBV focal points participated in the initial training sessions along with clinic case officers for DV to clarify roles Nomination of clinic case officers for DV (nurses) to lead DV response in the study clinics
Financing and other resources (staff, infrastructure, supplies)	<ul style="list-style-type: none"> No dedicated budget for DV response; reliance on international donors Limited staff and no additional resources to fund any psychosocial services on site Lack of privacy at clinics when asking about DV 	<ul style="list-style-type: none"> MoH commitment to improve privacy at clinic level Importance of privacy stressed during intervention's training and one clinic allocated a private room for counselling DV cases Clinic case officers for DV to counsel on DV in a private room
Co-ordination and community engagement	<ul style="list-style-type: none"> NRS in place (guidelines), though limited intersectoral co-ordination and little communication across partners Limited implementation at clinics as MoH is not fully involved in NRS Limited referral services (also due to political occupation) Fear of community stigma impacting on DV service uptake None of the women wanted referral to GBV focal points or external referrals (because of limited mobility and fear of stigma) Limited HCP agency (and authority) to refer cases externally—still have to defer to GBV focal points Limited authority of GBV focal points as they also defer to high-level senior authority for difficult cases 	<ul style="list-style-type: none"> Reinforcement training sessions further clarified the role of clinic case officers for DV and the referral pathways (e.g. standard practice for all providers to always refer DV cases to clinic case officers for DV) Community awareness sessions organized at study clinics with support from MoH GBV focal points were included in all the initial training sessions—to make the link between the clinic roles and their role and let people know who they are
Health workforce	<ul style="list-style-type: none"> Some (though limited) national MoH training on DV—mainly focus on identification and referral Training targeting nurses but not cascading to other staff Low staff knowledge and capacity on DV, paired with traditional attitudes towards DV led to staff not getting involved in DV cases 	<ul style="list-style-type: none"> Integration of discussion on staff security in the training content Training intervention to raise DV awareness of all clinical staff not just nurses (e.g. laboratory technicians who had some contact with women patients) Use of actual histories of survivors of DV identified in the clinic (done safely and protecting survivors')

(continued)

Table 4 (continued)

HS framework dimensions for readiness	Key findings (macro and facility levels)	Impact and suggestions for improving intervention
Information	<ul style="list-style-type: none"> • High workload and limited staff time • HCP fear of family retaliation and concern over own security leading to them refraining from identifying and/or documenting DV cases • National DV health information system in place—though not uniformed and consistent • MoH policy on DV documentation at facility level (with specific forms for recording DV cases) though limited policy implementation due to widespread underreporting of DV by women and front-line workers' discretion in recording DV • Lack of clarity among HCP on who should be documenting DV cases 	<p>confidentiality) for discussion in reinforcement sessions</p> <ul style="list-style-type: none"> • Importance of documenting and recording survivors of DV in clinic registration book was also emphasized during the pilot training and reinforcement sessions

HCP, health care providers; HS, health system.

referred, thus using their discretion in applying the policy to respect women's wishes.

Provider's fear of family retaliation also affected their decisions to document cases of DV. Despite the confidentiality of the reporting process, some providers would not report DV cases because they were scared they might be threatened by the woman's family.

Confidential. It is confidential, and only reaches the people it is meant to reach. Like if I discover a case quietly sometimes I don't agree to write it down, or I just don't write it. Why? Because I'm the only one who knows about it, and the family knows that now, I'm the only one who knows about it. As soon as that news gets out, I might get threatened (HP02).

There was also some lack of clarity regarding whose job it was to document the DV cases.

So if I were to encounter a [DV] case, for example... I expect that the nurses who have been instructed and the role has fallen upon them, they would refer immediately to the social worker and if she needs the doctor, she refers. My role is exceptional here; I don't see the abused patient (HP11, male doctor).

Some also reported the lack of time because of the large number of patients as a challenge to recording DV data.

We do not document cases [of DV] right now, although there is a protocol present in the clinic corridors that limits the requirements from a sample of these patients. But we run out of time [...]. ...Currently, there are forms in this specialty, but they are not applied because of time [constraints] (HP06).

Discussion

This study is the first to assess HSR for adopting a DV intervention in a low middle income country. Our findings highlight the partial readiness of systems and the clinics we studied in oPT to respond to DV. Key system deficiencies that emerged at both national and facility levels included: mixed views on DV as a priority issue among managers and providers; lack of clear health guidance on DV; a leadership and support vacuum from senior management, which limited the confidence among staff; piecemeal co-ordination between MoH and other

sectors; limited agency of GBV focal points and PHC providers to manage DV cases despite their attempt to show leadership and willingness; reduced or lack of privacy; and low staff awareness of DV and of the importance of their potential role. Table 4 summarizes key results.

Organizational climate and how providers perceive conditions in their organization are the predictors for effective implementation of an intervention (Kelly et al., 2017). Our study shows that the fear of retaliation and the perceived lack of support in the facility environment could affect the adoption of the DV intervention.

In line with existing health systems research literature on DV—and VAW more broadly (Goicolea et al., 2015; Colombini et al., 2017), the study findings reveal interlinked obstacles cutting across dimensions and levels (macro and meso). Weaknesses in one dimension have a knock-on effect on other system's dimensions. For example, limited political will and leadership on VAW at national level led to weaker policy guidance on DV, which in turn affected front-line staff awareness of DV procedures, also influencing their agency and confidence to act—especially of GBV focal points, who did not have support from their superiors. Values and beliefs that reinforced the notion of DV as a private matter and outside of the purview of health-care providers affected motivation and political will at leadership level, which in turn influenced funding allocation and adoption of new policies and protocols at the national and sub-national levels. For the Palestinian context, improving governance (clear guidance on DV, clarity of roles) and capacity of the health workforce (DV awareness, safety), while promoting positive values and beliefs about DV across all national and subnational actors, were important elements that needed to be strengthened prior to adopting the new intervention. Combinations of the system's elements help us understand the complexity of the health system and assess its capacity, without prioritizing some dimensions over others.

Another important result was the critical influence of 'software' issues of the HS (e.g. values, leadership and support). Even if all the 'hardware' elements are in place (e.g. policies, human resources and infrastructure), the materialization of collective readiness is dependent on the software elements also being ready. However, these are often neglected by intervention planners. For example, despite the MoH policy guidance on documenting VAW cases at health facilities, the lack of clarity of this MoH policy and the health staff's own value systems (which could also conflict with MoH policy

guidance), resulted in front-line health-care providers using considerable discretion when implementing the policy (often resulting in inaction in relation to VAW recording and identification).

Our findings highlight a complex interaction between the agency of PHC providers in responding to DV and the value systems, normative and social structures and organizational systems that shape their work practices. For example, the limited availability of services to which health-care providers could refer women, women's restricted mobility to access psychologists and social workers outside of the PHC clinic and the political occupation creating further reduced mobility, impacted the uptake of external referral and also reduced providers' agency to refer women. Several studies have demonstrated how structural working conditions, clients' attributes and broader cultural (extra-organizational) factors should not be underestimated during intervention development and implementation (Lipsky, 1980; Weiner, 2009; May, 2013; Gilson, 2015; Kelly et al., 2017).

Behind the weakening of collective commitment among some providers to address DV is the limited health systems capacity in oPT. Though critical for organizational readiness, overall health system capacity and motivation to implement/use an intervention are often overshadowed in implementation strategies by specific intervention capabilities (Scaccia et al., 2015). Our study has shown anticipated readiness gaps specific to DV intervention capacity and also highlighted broader deficiencies in the oPT PHC health system capabilities generally. For instance, human resources were a challenge in overcrowded PHC clinics where providers are few and have little time to deal with an additional innovation.

Study findings also reported very low disclosure and uptake of DV services by women in the study clinics. This could be because of wider cultural values on traditional gender roles affecting women's mobility, or because of the stigma associated with taking actions that would bring shame to the family or end the marriage. Women's concealment of experiences of violence was also a challenge when recording cases at facility. Health interventions often do not consider that women at an early stage of change may not necessarily recognize or be able to define what they are experiencing as violence (Reisenhofer and Taft, 2013). The training of providers should include understanding women's progression in the pathway from recognition to action, reasons they may not want to discuss, and provide them with skills to be able to support women at different stages in the process of change and decision-making (Reisenhofer and Taft, 2013).

Using the HSR assessment for intervention adaptations

To be able to enhance the uptake and effectiveness of a new, adapted or modified intervention by health systems and services, it is critical to analyse and understand their readiness (de Savigny and Adam, 2009). As a precursor to the implementation of the DV pilot intervention, the HSR assessment anticipated preparedness gaps and informed adaptation of the intervention. For instance, to address the limited DV disclosure and uptake of DV services, community awareness sessions were organized. Furthermore, to overcome the lack of clarity around roles and the limited co-ordination, GBV focal points participated in the initial training sessions of the pilot intervention, Table 4 offers more examples of how some of the results of the HSR shaped the DV intervention prior to implementation.

The HSR assessment also highlighted systemic issues that were crucial for surfacing intervention assumptions and contextual issues for the evaluation of the intervention. It also proved useful to assess linkages across the macro and meso (facility) levels (Rice, 2013).

Limitations and strengths

The innovative aspect of the HSR assessment is to inform a better understanding of the health system's elements that need to be in place before integrating DV programmes into routine health care. Since these elements determine both the uptake and the quality of the intervention, they should be part of intervention design.

A health system's readiness assessment can identify weaknesses in systems' and services' capacity to adopt a DV intervention but cannot guarantee implementation effectiveness. However, by highlighting elements that need to be strengthened and conditions that are key for guaranteeing quality implementation, it can increase the chances of successful implementation of an intervention (Aarons et al., 2011).

Methodologically, in line with recommended standards on organizational change measurement (Shea et al., 2014), we were able to generate valid data as we collected views from a range of respondents from the same organizations and agency networks to enable assessment of both individual and collective readiness.

Conclusion

This is the first study to assess system and service readiness for implementing a DV intervention. Findings identified concrete areas for action in seven dimensions of the health system that were important for strengthening the adaptation and effective delivery of the intervention. More research is needed on how to enable health systems to be 'ready' to deliver effective, quality services for survivors of DV and, more broadly, VAW.

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